Paid Family Leave
STATEMENT OF RIGHTS

If you need to take time off from work to care for a family member, you may be entitled to Paid Family Leave benefits.

Paid Family Leave is employee-funded insurance that provides eligible employees job-protected, paid time off to:

- **BOND** with a newly born, adopted, or fostered child;
- **CARE** for a family member with a serious health condition (see **paidfamilyleave.ny.gov** for eligible family members); or
- **ASSIST** loved ones when a spouse, domestic partner, child or parent is deployed abroad on active military service.

Eligibility:

- If you have a regular work schedule of 20 or more hours per week, you are eligible after 26 consecutive weeks of employment with your employer.
- If you have a regular work schedule of less than 20 hours per week, you are eligible after working for your employer for 175 days, which do not need to be consecutive.

Citizenship or immigration status is not a factor in your eligibility.

Benefits:

You can take up to 12 weeks of Paid Family Leave and receive 67% of your average weekly wage, capped at 67% of the New York State Average Weekly Wage. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting Paid Family Leave. Leave can be taken all at once or intermittently, but must be in full-day increments.

Rights and Protections:

- **Job protection**: Return to the same or comparable job after you take leave.
- You keep your **health insurance** while on leave (you may have to continue paying your portion of the premium costs, if any).
- Your employer is **prohibited from discriminating or retaliating** against you for requesting or taking Paid Family Leave.

Disputes:

If your Paid Family Leave claim is denied, you may request to have the denial reviewed by a neutral arbitrator. The insurance carrier listed below will provide you with information about requesting arbitration.

Discrimination Complaints:

If your employer terminates your employment, reduces your pay and/or benefits, or disciplines you in any way as a result of you requesting or taking Paid Family Leave, you may request to be reinstated by taking these steps:

1. Complete the ***Formal Request for Reinstatement Regarding Paid Family Leave (Form PFL-DC-119)***.
2. Send your completed form to your employer and a copy of the completed form to:
   Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. If your employer does not reinstate you or take other corrective action within 30 days, you may file a discrimination complaint with the Workers' Compensation Board using the ***Paid Family Leave Discrimination/Retaliation Complaint (Form PFL-DC-120)***. The Workers' Compensation Board will assemble your case and schedule a hearing.
4. There are other state and federal laws that protect employees from discrimination. Additional information is available at **PaidFamilyLeave.ny.gov**.

Paid Family Leave Request Process:

1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the ***Request for Paid Family Leave (Form PFL-1)*** to your employer.
3. You must submit your completed request package to your employer's insurance carrier within 30 days after the start of your leave to avoid losing benefits.
4. In most cases, the insurance carrier must pay or deny benefits within 18 calendar days of receiving your completed request or your first day of leave, whichever is later.

You may obtain all forms from your employer, their insurance carrier listed below, or online at **PaidFamilyLeave.ny.gov/Forms**.

For more information, forms and instructions, visit PaidFamilyLeave.ny.gov or call the PFL Helpline (844)-337-6303

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's Paid Family Leave benefits insurance carrier is:

ShelterPoint Life Insurance Company 1225 Franklin Avenue. Ste. 475 Garden City, NY 11536 Fax: 516.504.6412 (main) | 516.504.6436 (service) | 516.504.6414 (claims) | Phone: 800.365.4999 | (516.829.8100)
www.shelterpoint.com

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Paid Family Leave
PO Box 9030, Endicott NY 13761

NEW YORK STATE | Paid Family Leave

EMPLOYEE OPT-OUT OF PAID FAMILY LEAVE BENEFITS

Information on the option to opt-out of paid family leave and directions for completing this form can be found on page 2.

Employer Information

1. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA) CHILDRENS LEARNING CENTER AT HUNTER COLLEGE - HC CHILDCARE	
2. ADDRESS 695 PARK AVENUE ROOM #207N	**4. EMPLOYER FEIN** 13-3549073
3. CITY, STATE and ZIP CODE NEW YORK, NY 10065	**5. TELEPHONE NUMBER** (212) 772-4066

Employee Information

6. EMPLOYEE NAME	
7. HOME ADDRESS	
8. CITY, STATE and ZIP CODE	**9. TELEPHONE NUMBER**

Employment Information

10. AVERAGE NUMBER OF HOURS WORKED PER WEEK (BASED ON LAST 8 WEEKS)	**12. IS THIS JOB TEMPORARY?** ☐ **YES** ☐ **NO**
11. AVERAGE NUMBER OF DAYS WORKED PER WEEK (BASED ON LAST 8 WEEKS)	**IF YES, HOW LONG IS THE JOB EXPECTED TO LAST?**

Employee Affirmation

1. I would like to waive paid family leave coverage at this time because (select one):

   ☐ I regularly work 20 hours or more per week, but will not work 26 consecutive weeks (6 months) for this employer.

   ☐ I regularly work less than 20 hours per week, but will not work 175 days in 52 consecutive weeks (a year) for this employer.

2. I understand that this waiver is revoked if my work schedule changes and it is anticipated I will work more than 20 hours per week for 6 months, or will work less than 20 hours per week but at least 175 days in a 52 consecutive week period (1 year).

3. I understand that this waiver is **OPTIONAL AND REVOCABLE**.
   (a) My employer may not force me to opt out of paid family leave benefits.
   (b) I may decide later to revoke this waiver even if my schedule does not change.

4. I also understand if this waiver is revoked (either by me or by a change in my work schedule), my employer may take retroactive deductions for the period of time I was covered by this waiver, and this period of time counts towards my eligibility for paid family leave.

Certification

I certify to the best of my knowledge the foregoing statements are complete and true.

Employer's Signature: _____ Date Signed: _____

Employee's Signature: _____ Date Signed: _____

Please note: Employer must keep a copy of the fully executed waiver on file for as long as the employee remains in employment with the covered employer.

If you need assistance, contact the Paid Family Leave Helpline at (844)-337-6303

www.ny.gov/PaidFamilyLeave

Opting Out of Paid Family Leave (12 NYCRR 380-2.6)

(a) An employee of a covered employer shall be provided the option to file a waiver of family leave benefits:
  (i) When his or her regular employment schedule is 20 hours or more per week but the employee will not work 26 consecutive weeks, or
  (ii) When his or her regular employment schedule is less than 20 hours per week and the employee will not work 175 days in a 52 consecutive week period.

(b) Within eight weeks of any change in the regular work schedule for an employee that requires the employee to continue working for 26 consecutive weeks or 175 days in a 52 consecutive week period, any waiver filed under this section shall be deemed revoked. An employee of a covered employer whose waiver has been revoked shall be obligated to begin making contributions to the cost of family leave benefits, including any retroactive amounts due from date of hire, pursuant to Section 209 of the Workers' Compensation Law, as soon as the employee is notified by the covered employer of such obligation.

(c) The covered employer shall keep a copy of the fully executed waiver on file to be produced at the request of the Chair, for as long as the employee remains in employment with the covered employer.

(d) An employee as described in Subsection (a) of this Section who elects not to enter into a waiver shall make regular family benefit contributions for the full duration of his or her employment with the covered employer, and the covered employer shall be obligated to provide family leave benefits for such employee when he or she is eligible pursuant to this Title.

Calculating Average Hours/Days Worked

To determine the average number of hours worked per week:
Add all hours worked for the past 8 weeks then divide the total by 8.

To determine the average number of days worked per week:
Add all days worked for the past 8 weeks then divide the total by 8.

Example:

Week Worked	Hours Worked	Days Worked
Week1	16	2
Week 2	24	3
Week 3	16	2
Week 4	16	2
Week 5	8	1
Week 6	24	3
Week 7	16	2
Week 8	8	1
Total	128	16
	Divide by 8	Divide by 8
Average Per Week	16	2